

STATE OF WASHINGTON



OFFICE OF  
INSURANCE COMMISSIONER

Market Conduct Examination  
of

Good Health Plan of Washington, Inc.

1501 Fourth Avenue, Suite 500  
Seattle, Washington 98101-1621

As of

November 30, 1995

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Seattle Washington

Deborah Senn  
Insurance Commissioner  
Olympia, Washington 98504

Dear Commissioner Senn:

Pursuant to your instructions and in compliance with the statutory requirements of RCW 48.46.130, an examination has been conducted to review the corporate affairs and market conduct activities of:

Good Health Plan of Washington  
of  
Seattle, Washington

Scope of Examination

The market conduct examination of Good Health Plan, henceforth referred to as the "Company" or "GHP" was conducted in accordance with procedures established by the National Association of Insurance Commissioners and the policies and procedures established by the Washington State Insurance Commissioner. The examination period covered January, 1, 1994 through November 30, 1995.

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## **EXAMINATION REPORT CERTIFICATION**

This examination was conducted in accordance with Office of the Insurance Commissioner and National Association of Insurance commissioners market conduct examination procedures. This examination was performed by Sally Carpenter, Fritz Denzer and Leslie Krier, who also participated in the preparation of this report.

I certify that the foregoing is the report of the examination, that I have reviewed this report in conjunction with pertinent examination work papers, that this report meets the provisions for such reports prescribed by the Office of the Insurance Commissioner, and that this report is true and correct to the best of my knowledge and belief.

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Pamela Martin

Chief Market Conduct Examiner

Office of the Insurance Commissioner

## **HISTORY OF THE COMPANY**

The Good Health Plan of Washington, Inc., is a not-for-profit corporation organized under RCW 24.06. On November 25, 1986, GHP was issued a certificate of authority by the Office of the Insurance Commissioner to act as a Health Maintenance Organization (HMO) in the State of Washington. GHP was established by Sisters of Providence to further the health of its members, to conduct its activities in compliance with The Ethical and Religious Directives for Catholic Health Facilities, to provide necessary health support to the poor and infirm, to provide cooperative and comprehensive programs of health care and, to develop more beneficial and sufficient methods of delivering health care services throughout Washington State.

The registered office of GHP is 1501 Fourth Avenue, Suite 500, Seattle WA 98101. Appendix I shows affiliated companies.

## **TERRITORY OF OPERATIONS**

GHP operates in the following Washington counties: Adams, Chelan, Clallam, Douglas, Ferry, Grant, King, Kitsap, Lewis, Lincoln, Mason, Okanogan, Pend Oreille, Pierce, Snohomish, Yakima, Skagit, Spokane, Stevens, Thurston, and Walla Walla. GHP does not operate outside of the State of Washington.

## **MANAGEMENT AND CONTROL**

The Good Health Plan is controlled by a Board of Directors and operates according to the Articles of Incorporation and Bylaws establishing Board powers, duties and responsibilities. The Bylaws state that the Board is to be composed of one-third Sisters of Providence personnel, one third HMO participating doctors and one-third public representation. On December 28, 1992 the Articles of Incorporation were amended to make Sisters of Providence the sole member of the corporation, removing the other initial corporate member, Washington Health Network.

As prescribed by the Bylaws, the Board is to consist of not less than 6 nor more than 18 members. As of August 1995, there were 8 members of the Board of Directors. The Directors are appointed by Sisters of Providence (SP) to serve a term of one year. Additional terms can be served.

The Directors as of July 1995 were:

Peter Bigelow	VP, WA Operations, Sisters of Providence	Chairperson
Bill Arnold	Sr. VP Franciscan Health Systems	Vice Chair
Raymond F. Crerand	CEO Providence Medical Center	Secretary
Earl D. Beegle, MD, ABFP	Providence Clairmont Clinic	Treasurer
Dick Layton, MD	Medalia Health Care	
David Brown, MD		
Don Blem	Advanced Technology Laboratories	
Emily R. Bingham	VP & Manager Seafirst Bank	
Vacant position		

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Until the vacancy is filled, the Company is not in compliance with its Bylaws nor is it in compliance with RCW 48.46.070 which requires that at least 1/3 of the governing body be consumers who represent the member population. A quorum to conduct business consists of a simple majority of the appointed Directors, provided at least two Directors are affiliated with enrollees and at least two physician Directors are present.

At the April 28, 1993 Board of Directors meeting for Sisters of Providence, a resolution was adopted charging the Directors of the Good Health Plan of Washington to "exercise routine oversight and direction over Sound Health Network, Providence Health Care, and the Good Health Plan of Washington." Since April 28, 1993 it appears that annual meetings are combined for all the named companies, with the GHP Board of Directors taking the leadership role in the sessions.

### **ADVERTISING**

The Company advertises by using printed advertisements in local papers, radio spots, agent sales/marketing brochures and provider materials.

The umbrella corporation, Sisters of Providence Health Plans (PHP), maintains a single advertising file for Providence Health Care and the Good Health Plan. The advertising file contained print copy of the following items: one magazine, two copies of Trend Line (a publication designed to keep employers updated on health care issues), six editions of Health Journal (member newsletter), nine tri-folded employee benefit brochures and enrollment kits (one each) for The Good Health Plan and Providence Health Care. During the examination, other advertising materials were found that had not been included in the advertising file. The Company has not retained all forms of advertisements and other communications directed at providers and the general public in their advertising file as required by WAC 284-50-200.

The name Providence Health Plans (PHP) appears to be the dominant entity on many of the advertising materials reviewed, while the name Good Health Plan appeared in secondary context. This creates the perception that the contracting entity is PHP rather than GHP. There is a great deal of redundancy in the labeling of affiliate operations and company benefit plans (Providence Health Plans, Good Health Plan, Providence Health Care, Providence Alternatives, Sound Choice, Sound Alternatives, Sound Health and Sound Health Select). OIC compliance officers have had difficulty in determining the carrier because all names appear in all materials.

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The OIC has discussed this problem with GHP in the past. There is concern that the average consumer may be unable to distinguish between the different affiliate organizations and benefit programs shown on enrollment materials and other advertising pieces. In 1995 the CEO and the OIC met to discuss the need to have the correct identity of the authorized entity prominently displayed in all materials. The Company was directed at that time to revise materials as necessary to ensure that the proper company was clearly identified in the materials.

Two pieces of sales material reviewed quoted Company statistics, but did not state the source of the numbers used. WAC 284-50-110(3) requires this information be included in all corporate advertising, endorsements and promotions.

## **AGENT APPOINTMENTS**

Business is marketed through agents and brokers who solicit employer groups, although it may be sold through a Company representative. During the examination period, agency appointments were a function of the Marketing Program Coordinator. Documentation of appointment procedures and the retention of agent and broker certificates and licenses has been inconsistent.

For the examination period, there were no appointment procedures and guidelines in place. The Company did make efforts to have agents appointed at the time a group application was received, but not prior to solicitation as required by RCW 48.46.023(2). Company personnel involved in direct sales activities were not appointed at the time of hire. Out of the 10 employees required to have appointments, only six had appointments prior to September 1995. All had been in sales positions prior to that date.

Nine group contract files were reviewed for active GHP agent appointments prior to solicitation. Six of nine agents were not appointed with GHP at the time they solicited the groups. Two of these were Company employees. Two agents were affiliated with brokers. Additional problems with agents identified as not appointed or late appointments are reviewed in the Underwriting and Rates section of this report.

The declined quote file was also reviewed to determine if agents were appointed in a timely fashion. Agents who had requested quotes were checked against OIC listings to determine if they were appointed with GHP. Only three of the 10 agents were appointed prior to the request for quote date. Five of 10 agents were never appointed. In two instances there was not enough information in the log to identify the agent involved to determine if they were appointed.

*Subsequent event: In 1996, the Company created written procedures for appointing agents with Good Health Plan and Providence Health Care. These procedures are written at the holding company level and are Company specific only in examples. In addition, appointments are now managed by the Regulatory Affairs Department, and procedures require appointment prior to any sales materials being distributed to new agents.*

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## CONSUMER COMPLAINTS

The Company has established a multi-tiered complaint handling procedure that has four levels. Company complaint logs were examined and compared against consumer requests for assistance submitted to the OIC. The complaints were evaluated to determine if a profile or pattern of grievance existed. The Company has developed procedures outlining how employees are to respond to OIC inquiries and complaints as well as customer inquiries, complaints and appeals.

A single log is maintained for consumer complaints for Providence Health Care, The Good Health Plan, and OIC complaints. Complaints for other entities such as Sound Health are entered into the same log at times. This adds confusion to the logs and creates extra entries. The log is maintained manually and displays limited information. Because of this, it is difficult to determine which inquiries are specifically directed at GHP, the type of complaint, or the resolution.

### OIC Complaint Handling

OIC records indicate twenty consumer complaints against GHP were received by the OIC in 1995. Two of these complaints involved Oregon claims and were referred to the Oregon Department of Insurance for handling. Eighteen were reviewed as part of this examination.

The 18 complaints received by the OIC were compared with Company complaint logs. Five were not on the Company logs. When GHP attempted to locate the missing items, they could not do so. During the examination period, complaints were handled by the department responsible for answering the complaint. They were logged into a central location, but no one person or unit was responsible for the log. All logs were maintained manually. No documentation was kept on the complaints.

Four of the 18 complaints reviewed met the 15 business day response time required in WAC 284-30-650. Average response time for all the complaints reviewed was 26.7 calendar days.

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### Appeals and Grievance Procedures

The Company maintains a Medical Management Appeals (MMA) Log. There is a multi-tiered complaint handling process for both Providence Health Care and Good Health Plan. This process consists of four levels for members to appeal claim decisions.

- Level I Appeals on claims less than \$250.00.
- Level II Appeals on claims over \$250.00 and for denied Level I appeals.
- Level III CEO review when a member requests Grievance Committee review for a denied Level II claim or when disagreements occur about denials at Level II, and further discussion is required before the member is advised of the action.
- Level IV Grievance Committee hearing.

Complaint file records for Levels I, II and III complaints were reviewed for both GHP and PHC for January 1, 1995 through October 31, 1995.

	Total Complaints	Reversed on Appeal
Level I	205	191
Level II	110	68
Level III	84	32
Level IV	0	0
Total	399	281

Of the total complaint population, 199 or 49% of the Level I, II and III appeals were from members who did not get pre-approval for treatment. It appears that this may be a trend and may require further member and/or provider education in this area. A summary of the complaints during the examination period shows:

- 49% of Level I, II and III appeals were related to the pre-approval process.
- 74.6% (235) of Level I and II appeals resulted in reconsideration and payment of the claim in question.
- 84 appeals reached Level III.

- 36% were related to medical necessity.

- 38% of the lower level decisions were reversed resulting in payment of the claim.

*Subsequent event: The Company has written policies and procedures for handling grievances and complaints. The procedure is dated 10/8/96, and establishes a centralized point of control for handling of grievances, appeals and complaints.*

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## **UNDERWRITING AND RATES**

Agents, brokers and employer groups may call GHP for quote requests. Agents and brokers are given a manual that describes GHP's history, mission statement and product line summaries. The manual does not give agents and brokers information regarding the types of groups desired by GHP. Because of this lack of information many groups are declined because the industry is not acceptable. The agent manual reviewed contained a majority of pages labeled as "Draft". The agent manual does not appear to be a finished document, but rather one that is in process.

Each new business quote request is logged in a new business quote sheet the day it is received. One log is kept for both GHP and Providence Health Care. Once a group chooses a benefit package, an application is completed. If the group does not meet the underwriting guidelines the group is declined. GHP does not write individual coverage.

Enrollment for group business is managed through the cooperative efforts of Marketing, Underwriting, Contract Services and Membership Services departments. Marketing handles quotes, Underwriting uses census information to determinate rates, Contract Services issues the final contract for delivery and communicates new and renewing enrollment information to Membership, Customer Service, and Claims. The Membership area is responsible for coding benefits into the system.

Combined company new business quote logs were reviewed. The new business quote logs were incomplete and lacking information in many fields. Six hundred and sixty quotes were received from January 1995 to October 1995. Two hundred and twenty three quotes were declined.

Eleven declined quote files were reviewed. Six groups were declined because they were not the type of industry desired by the Company. Three groups were declined because more than 10% of the members fell outside of the Company's service area, but they were offered a non-HMO product. This is consistent with the Company's underwriting guidelines requiring no more than 10% of a group's enrollment to be outside of the Company's geographical service area. Declinations for two groups had no file documentation to substantiate the decline action.

Nine group files (new and renewing contracts) were reviewed. Because of the random sample selected, there were groups that had new business effective dates in 1996. Rate

filings were reviewed for 1994, 1995 and 1996 for groups that were new or renewing during 1994, 1995 and 1996. It appears that rate filings during the examination period were not controlled by the Company. Our review of the 9 new and renewing groups found that:

- The Company did not file rates for basic coverage and two riders for one group.
- Rates for one negotiated group and five riders for 1995 were not filed. GHP Regulatory Affairs personnel believe that the negotiated group was issued a standard contract and therefore did not require a separate filing of the negotiated rate.

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Rate filing, rate calculations and billed rates were reviewed for selected groups. Base rates matched those filed with the OIC, but rating factors did not. In discussing the rating system with GHP's Analytical Services Department, the Company stated that in August 1995, they began testing a new rating model that used unfiled rates. The test continued until September 1995. When the test was completed, the Company continued to use the unfiled rates and factors in the rating model for new business quotes and renewal processing of existing groups. In addition, the Company renewed a number of groups "off-anniversary" in November 1995. These cases were renewed using the unfiled rates.

Between August 15 1995 and December 31, 1995, 106 groups were considered for quote by GHP and Providence Health Care. Sixty eight (68) were declined. Thirty six (36) were quoted using the unfiled rating model. Two groups were sold and forty-one (41) groups renewed using the non-filed rating model. These figures represent both GHP and Providence Health Care groups.

*Subsequent Event: 1996 rates and rating factors were reviewed to determine if the Company was currently using filed base rates and filed factors in the automated rating program. According to the sample group calculations, both 1996 filed rates and factors were being used in the rating system for 1996 calculations.*

*Subsequent event: On 1/17/97 the Company established a procedure for filing of rates and forms. The procedure requires all filings to be coordinated through the Regulatory Affairs Department.*

## **CONSUMER CONTRACTS**

The membership handbooks are easy to read and understand. The handbook covers who is involved in the plan, how to use the plan, and what the benefits are. The organization of the handbook has two drawbacks. First, the Definitions section is in the back of the book. The other is that while the Exclusions and Limitations are a separate item under the Schedule of Benefits, they are not mentioned in the Table of Contents and may be overlooked by members.

During the examination period, Good Health Plan filed standard forms, contracts and rates annually. Historically they have been filed in December for an effective date of January 1 of the following year. Endorsements and amendments are filed as needed during the year. Upon review of contracts, amendments and endorsements, we found one member handbook and one contract page that were not filed prior to use. In addition, 5 riders were filed after use and 5 were not filed at all. See Appendix 2 for a listing of these forms.

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A negotiated contract amendment and a negotiated contract endorsement were mislabeled on filing face sheets as standard contract pages.

The prior examination dated December 31, 1989 instructs the Company to adhere to filing requirements as set forth in RCW 48.46 and WAC 284-46. It appears from this examination that the Company does not have adequate control over filing procedures, and that violations continue to occur.

#### Termination of Contracts for Non-Payment of Premium

When a premium is not paid by the due date, the Company begins procedures to collect the premium. Company procedures state that on the 10th day after the due date, the accounts receivable accountant (A/R A) generates a list of groups that are late paying premium. This list is broken down by account representative (AR), and sent to the appropriate AR. The AR has 3 days to contact the group. If they are able to contact the group, they negotiate a payment date. There is no established time frame for the late payment date that may be negotiated by the AR. If the AR is unable to reach the group, the notice is returned to the A/R A to send out a late notice. If payment is not received by the negotiated payment date, the A/R A then notifies other departments that the group is late in paying their premium. It is at this point that the Claims Manager is notified to put the group on "hold".

There is no procedure established to ensure that providers are advised of the delinquent status of group. If a provider calls the Company for pre-authorization of treatment, they are notified of the change of status once the eligibility information is updated on the system. Other vendors, such as MCC Behavioral, are advised of eligibility status by a monthly report sent to their offices. As updates to the eligibility listings are done only on a monthly basis, the vendor and the Company may be relying on outdated information to pay claims and pre-authorize treatment.

The Company stated that it is normal for the late payment to be received within 20 days of the original due date. However, in reviewing Company records, it was found that it is not unusual for payments to lag by 30 to 60 days. At the end of 1995, 28 groups were in the 0 - 30 days late category, 10 were in the 31 - 60 days late category and 12 groups were in the over 60 days late category. The Company states only 1 group has been sent to collection to recover back premium, and none have been canceled for non-payment.

Claims received or services provided for enrollees from late paying groups are handled as if payment was current. Any adjustments are made when the Company determines that the group has lapsed.

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## **PROVIDER CONTRACTS**

During the examination period, the Provider Relations Department was responsible for submitting provider contracts to the Office of Insurance Commissioner for approval. As needed, the Company's legal staff served as consultants and assisted in drafting contract language.

During the examination, we reviewed the standard contract language as filed with the OIC. There are currently 14 standard provider contract forms. It was found that 4 of the standard forms were not filed with the OIC as required by RCW 48.46.243 and WAC 284-46-575. The other contracts were found to contain the hold harmless and insolvency language as required. We also found that when the Company initially filed their basic provider contract form, it was not approved as wording in one section needed to be changed. The Company did revise the form and refile as instructed. This form was approved. However, they recontracted all providers using the disapproved form. This was not detected by the Company until this examination.

Sixteen (16) provider contracts were selected for review. These were chosen randomly from the 1995 Provider Directory. Signatures were found to be missing on 3 files. In addition, 4 contracts were signed after the effective contract date. Contracts for one provider could not be found. Five (5) contracts used unfilled forms. File documentation was found to be inconsistent and incomplete.

The market conduct examination as of December 31 1989 found that the Company did not file provider contracts with the OIC. The Company was instructed to rewrite their provider contracts to comply with the law concerning hold harmless and insolvency language, and to file them with the OIC. It appears that the Company did comply with this instruction at the time it was issued.

*Subsequent Event: The Company has assigned responsibility for provider contract filings to the Regulatory Affairs Department. They are in the process of refileing all forms of provider contracts with the OIC.*

## **ADMINISTRATIVE CONTRACTS**

Chemical dependency and mental health services are provided for by GHP through MCC Behavioral Care, Inc. (MCC). The Company was able to furnish a copy of the original contract with MCC dated July 1, 1989. There have been five (5) amendments to this contract. Most deal with changes to the capitation amounts. Amendment 3, dated July 21, 1993 includes hold harmless and insolvency language required by WAC 284-44-240.

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## CLAIMS ADMINISTRATION

GHP business is processed on the SureCare claims system. All claims are submitted on paper, as the Company does not have the ability to receive electronic claim information. Claims are micro-filmed upon receipt and batched by line of business before being entered into the system. The final adjudication of a claim can occur either in the nightly system cycle or through the Company's weekly batch voucher processing system. Vouchers and advices-of-payment for capitated programs are run weekly.

The SureCare system automatically checks enrollee eligibility, identifies duplicate services and flags user defined Common Procedural Terminology (CPT) codes for manual review. The Company that designed the SureCare system is no longer in business, therefore original vendor support to update or modify the system is not available. Any system changes or modifications are done by the Information Systems unit at GHP.

The SureCare system is unable to process multiple dates of service on a claim. This means that claims with multiple dates are split, with each date of service being assigned a separate claim number. The system is also unable to automatically accrue Coordination of Benefits (COB) savings.

Good Health Plan automatically denies claims when there is an indication that other coverage may be available (coordination of benefits). The provider and enrollee are advised of the denial and instructed to send in payment information from the other carrier. The Company does not follow up to ensure that the required information is received. WAC 284-51-090 requires that a Company use all means available to facilitate coordination of benefits with the other carrier. GHP does not do this, and is in violation of this regulation. WAC 284-51-100 requires a company to pay as primary carrier if, after a reasonable period of time, they are unable to obtain information indicating another carrier is the primary carrier. The procedure followed by GHP during the examination period does not comply with WAC 284-51-100.

Training for claim processors and examiners is conducted by lead processors, supported with written procedures. Training is reinforced through feedback from weekly quality assurance audits.

According to the "Good Health Plan 1995 Claims Processed Chart", it took an average of 42.7 days to process a claim from January 1995 through October 1995. The company's "1995 Key Business Indicator Report" shows that GHP's average claim turnaround was 17.9 days. A sample of 61 claims from 1-1-95 to 9-30-95 were reviewed for adjudication accuracy and timely payment. The sample was selected by GHP's CPA firm as part of their annual audit. We found the average claim turnaround time on this sample to be 58.5 calendar days. Our sample claim turnaround time is calculated from the mail room receipt date (MRD) thru the final action date. During the exam process, the Company stated that

one reason for the long turnaround time is that about 75% of their capitated claims are returned to the provider for missing referral paperwork.

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Duplicate claims and rebilled claims are not consistently entered into the SureCare system. This is significant for two reasons. First, there is not an accurate count of the number of claims processed by GHP. Second, if these claims are not entered into the system, the Company has no way to track them. In both instances, the Company does not have control over the amount of work being processed in the Claims Department. Duplicate and rebilled claims represented 8% of our sample.

*Subsequent Event: In mid-1996, the Company completed a project to determine ways to expedite claims handling. The result of this project is revised work flows, increased check production to 2 times per week, a claim number tracking system, enforcement of a provision in the provider contract that requires providers to respond to all correspondence on claims within 7 days, and a new accounts payable holding report for review of pending claims.*

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## **GOOD HEALTH PLAN**

### **SUMMARY OF EXAMINATION FINDINGS**

#### **INSTRUCTIONS**

#### **Advertising**

1. WAC 284-50-200 requires that every insurer maintain a complete file of all advertising material. The advertising file reviewed as part of this examination did not contain all the advertising material. Good Health Plan is instructed to comply with WAC 28-50-200. (page 5)
2. WAC 284-50-110 requires that the source of statistics used in advertising be included in the ad. GHP is instructed to adhere to this requirement in all future advertising, or reprinting of current advertising. (page 5)
3. GHP is instructed to comply with WAC 284-50-150(1)(2), requiring the full name of the Company on all advertising material. While the name of the parent company may be shown, the primary focus must be on the full name of the authorized carrier for the product advertised. (page 5)

#### **Consumer Complaints**

4. WAC 284-30-650 requires that a company must respond to all correspondence from the OIC within 15 business days. The Company is instructed to change procedures to ensure compliance with this regulation. (page 7)

### **Agent Activity**

5. RCW 48.46.023 requires that agents and companies who solicit business on behalf of an HMO be appointed prior to soliciting business for them. The Company is instructed to immediately require appointments for all agents and Company personnel selling and soliciting on behalf of the Company. The Company is further instructed to cease transacting business with non-appointed agents. (page 6)

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### **Consumer Contracts**

#### **Underwriting & Rates**

6. RCW 48.46.060(5) requires Health Maintenance Organizations to file all contracts and rates with the OIC prior to use. RCW 48.46.030(7), final paragraph, requires that any changes or modifications to contracts or rates be filed with the Commissioner.

(a) During the examination, it was found that the Company created a new rating model for use by underwriters in quoting rates. The rates were used for a period of 5 months, and were never filed with the OIC. There were 36 groups quoted for GHP and Providence Health Care plans using the unfiled model, two of which were sold. In addition, there were 41 groups renewed in both companies using the unfiled rating model.

(b) During the examination, we found nine (9) contract forms, amendments and endorsements that were not filed before they were used, and five (5) that were never filed (ACC-94-ALTMEM, CSR-94-ALTMEM, DME-94-ALTMEM, TMJ-94-ALTMEM AND VIS-94-MEM).

The Company is instructed to immediately file the five forms listed above. In the future, the Company is instructed to file all rates, contracts, endorsements and amendments prior to use.

NOTE: Non-filing or late filing of rates was an issue in the prior examination dated December 31, 1989. An instruction

was given to the Company to comply with Washington filing requirements. The Company is urged to strongly consider changes in procedures to ensure that all filings are made as required. (page 10)

### **Provider Contracts**

7. GHP is instructed to file all provider contract forms prior to their use as required by RCW 48.46.243 and WAC 284.46.575. In addition, they are instructed to:

a) Cease using disapproved participating provider contract forms and to recontract with participating providers using the contract language approved by the Office of Insurance Commissioner on June 23, 1994.

b) File the participating agreements labeled, GHP ANCILLARY, GHP PREFCON, GHP PCPCON and GHP INSTCON as these documents have not been previously submitted for approval.

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NOTE: Use of disapproved and unfiled provider contract forms was an issue in the prior examination in 1989. This continues to be a problem with GHP. (page 12)

### **Claims**

8. WAC 284-51-090 and WAC 284-51-100 require the Company to actively pursue COB information via all means available to them. If, after a reasonable period of time and a reasonable effort on the Company's part to obtain this information, the Company still does not have the information needed to process the claim as the secondary carrier, the Company must pay as the primary carrier. The Company is instructed to immediately establish a procedure to reflect a "pay and pursue" method of adjudication as required by Washington COB regulations. (page 13)

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## **RECOMMENDATIONS**

The following items were noted during the examination as either operational weaknesses or potential problems. It is therefore recommended that Good Health Plan implement the following and take appropriate action to make improvements in these areas.

1. Many of the records for Providence Health Care, Sound Health Network and Good Health Plan are intermingled. As two of these companies are separately authorized entities and the third is an unregulated preferred provider organization, it is important for regulators to be able to distinguish between records for each entity. It is recommended that the Company keep separate records for each company in all phases of operation.

2.. In several areas file documentation and written procedures have failed to keep up with changes within the Company. Controls are insufficient to ensure that file documentation and procedures are in place. It is recommended that the Company aggressively pursue measures to create written procedures for every operational area. Some of the areas found to be lacking in controls are:

- a. Quote logs for new, renewing and declined business. Logs should be completed to ensure accuracy and consistency of the quoting process, and to have historical data available for future inquiries and quotes. (Page 4)
  - b. Documentation of OIC filings (rates, handbooks, group contracts, endorsements, provider contracts). This includes the need to keep historical filing documentation for all rates and forms, and to maintain separate records for each Company. (Page 13)
  - c. Maintain separate complaint logs for each company. Documentation should include enough information to give a brief description of the complaint, who handled it, elapsed time from receipt to completion, and the final resolution. This information should be reviewed on a regular basis by management, and the information used to evaluate training needs, trends and possible problem areas. (Page 9)
  - d. It is further recommended that procedures for each company be documented, and that each procedure contain the effective date, the procedure it replaces and the date of that procedure. A central control point should be established to ensure that procedures are distributed to all manual holders. The control point should also keep all versions of a procedure to ensure a historical file of company operations is maintained.
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3. It is strongly recommended that the Company implement tighter controls on delinquent groups.

Providers and members rely on accurate information from GHP concerning eligibility for services. It is important that late pay status be communicated to groups and providers immediately. Retroactive termination of a group results in provider payment being reversed and the provider seeking payment from the member. The hold harmless provisions of the provider contract will be void from the retroactive termination date. (page 10)

4. It is recommended that the "Limitations and Exclusions" section of the member hand books be included in the Table of Contents, so that a member can easily find this information when needed. (Page 10)

5. The Company should change procedures to account for all claims received by entering all claims into the automated system. (Page 11)

6. It is recommended that the Company develop a provider ID system or modify the existing one to track multiple provider billings. GHP providers are paid based on a variety of benefit programs and payment reimbursement schedules. (Page 11)

7. Claim processing time is calculated differently within the company. It is recommended that the Company implement a single standard of performance. (Page 11)

8. The Company needs to clarify Amedical necessity A and prior approval requirements to providers and to their membership. It was noted during the review of Company complaint records that 36% of Level III complaints involved a question of medical necessity. 49% of the overall membership complaints arose from members not obtaining prior approval for services, receiving non-approved services, and/or not using the required referral process. (Page 7)

9. GHP needs to develop clear physician referral procedures. The current referral process provides no direct access or linkage between providers and the Company. As a consequence, claims are delayed when referral claims are returned to providers for additional information. (Page 12)

10. It was noted during the examination that the Company does not consistently obtain provider signatures on participating provider agreements. It is recommended that the documents be signed and dated prior to the effective date of the contract and a copy of the signed contract retained in GHP's file. It is further recommended that all contracts not signed and dated must be amended to show signatures and dates to

effectuate the contract, and ensure the consumer protections of the hold harmless and insolvency provision are in place. (page 12)

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**ACKNOWLEDGMENT**

Acknowledgment is hereby made of the cooperation extended to the examiners by all the employees of The Good Health Plan of Washington during the course of this examination.

In addition to the undersigned, acknowledgment is made of the participation in the work and preparation of this report by: Fritz Denzer and Sally A. Carpenter, Market Conduct Examiners from the Office of the Insurance Commissioner of the State of Washington.

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**APPENDIX 1**

**AFFILIATED COMPANIES**

Sisters of Providence in Washington
91-725998

Sisters of Providence Health Plans in Washington
91-1317364

The Good Health Plan in Washington	Providence Health Care	Sound Health
91-1354269	91-1559981	Network

		(PPO)
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## APPENDIX 2

### Consumer Contracts not filed or late filed.

<u>Form Number</u>	<u>Exam Finding</u>
94-GHP-GTE-PL-505	Filed after use.
94-GHPPAMH	Filed after use.
Riders:	
Rx 5/8-94 ALT	Filed after use.
Rx 8/15-95 ALT	Filed after use.
Rx 5/12, 7/12 94-ALT	Filed after use.
Rx 15-94ALT	Filed after use.
Rx 50/10-94ALT	Filed after use.
ACC-94-ALTMEM	Not filed.
CSR-94-ALTMEM	Not filed.
DME-94-ALTMEM	Not filed.
TMJ-94-ALTMEM	Not filed.
VIS-94-ALTMEM	Not filed.